Short Term Medical Plans

In times of transition and change

States:
AZ FL IA IL MS NE TX WI WV

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Health insurance available only to members of FACT.

These health insurance plans are issued as association group plans and available only to members of FACT, the Federation of American Consumers and Travelers. Golden Rule Insurance Company is the underwriter and administrator of these plans. See last page for more details.

THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DO NOT HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

UnitedHealthcare®

Golden Rule Insurance Company

Certificate Forms C-016.1, C-016.1-42 and other state variations; Certificate Form GRI-STAG16-C-EPO and state variations

Short Term Medical
Understanding How it Works

A Choice of Coverage to Fit Your Specific Needs

You select the term from 30 days to less than 3 months, then choose your deductible, and coinsurance that fit your budget. See pages 3-4 for a comparison of the plans available. Once you meet your deductible, you pay a percentage of covered expenses (coinsurance) to the coinsurance out-of-pocket maximum amount you selected. Then insurance pays 100% of the remaining covered expenses to the lifetime maximum benefit.

UnitedHealthCare Choice Network Advantages

Receive quality care at reduced costs because the network providers have agreed to lower fees for covered expenses. The large network of doctors and hospitals offer choices across the nation, so even when you're traveling, you're likely to find in-network care. You must use a network doctor or hospital. These plans pay no benefits for out-of-network expenses except for emergencies. See page 6 for more details.

This is an outline only and is not intended to serve as a legal interpretation of benefits. Reasonable effort has been made to have this outline represent the intent of contract language. However, the contract language stands alone and the complete terms of the coverage will be determined by the policy. State specific differences may apply, see pages 9-12.

Top Questions

Why should I consider this coverage? These plans can help bridge the gap in coverage if you: (a) must wait until the next Open Enrollment or are waiting for other coverage to begin; (b) are between jobs; (c) retired early; or (d) just graduated college. Keep in mind that you may owe an additional payment on your taxes because these plans are not ACA-compliant.

Is there someplace I can view and keep track of my benefits? Yes, with myUHOne.com you'll have access to your plan benefits and the ability to track your claims online. This member site also allows you to search for providers in your network and print copies of your ID card and certificate.

Highlights of Covered Expenses

Network Expenses Only - Per Covered Person, Per Term

You must use a network doctor or hospital with these plans. No benefits will be paid for expenses from a non-network provider except for emergencies. See page 6.

Lifetime Maximum Benefit we will pay (per person):	$600,000 on these plans

Short Term Medical Plans:		Value Select	Plus Select	Copay Select	Plus Elite
Length of Coverage		Choose length of coverage: from 30 days to less than 3 months.			
Deductible Type		Per Term (One deductible for selected length of coverage)			
Deductible Amount (per person)	You pay up to:	Choose $1,000[1], $2,500, $5,000, $10,000, or $12,500			
> Option: Add Supplemental Accident Benefit	We pay up to:	$1,000[1], $2,500, $5,000, $10,000, or $12,500 (Choose any amount to help cover your expenses in the case of an accident.)			
Coinsurance (% of covered expenses you pay after deductible)	You pay:	Choose 30% or 40%	Choose 20% or 40%	20%	0%
Coinsurance Out-of-pocket Maximum (after deductible, per person, copays not included)	You pay up to:	Choose $5,000 or $10,000	Choose $2,000, $5,000 or $10,000	$5,000	$0

Doctor Visits[2]

Doctor Office Visit, History, and Exam only	You pay:	Chosen coinsurance after deductible	Chosen coinsurance after deductible	$50 copay (first visit)[3]	Coinsurance after deductible
Urgent Care Center		$75 copay			

Outpatient[2]

Emergency Room	You pay:	$250 copay, then subject to deductible and coinsurance.
Outpatient Surgery, Labs, X-rays, and PSA Screening		Coinsurance after deductible

Inpatient[2]

Hospital Services	You pay:	Coinsurance after deductible

Pharmacy[2]

Prescription (Rx) Drugs ($3,000 max benefit)	**Not covered.** Discount Card only[4]	**Preferred Price Card & coinsurance after deductible** You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us with the Preferred Price Card. Once your plan deductible is met, you then pay only your coinsurance.

[1] $1,000 option not available with the Plus Elite plan.
[2] Expenses for injuries are eligible for coverage as of your plan's effective date; expenses for illnesses are eligible for coverage beginning on the 6th day following the effective date.
[3] Additional visits subject to deductible and coinsurance.
[4] Discount card can help you save an average of 20-25% on your Rx drugs. Discounts vary by pharmacy, geographic area, and drug.

Highlights of Covered Expenses

Network Expenses Only - Per Covered Person, Per Term

You must use a network doctor or hospital with these plans. No benefits will be paid for expenses from a non-network provider except for emergencies. See page 6.

Lifetime Maximum Benefit we will pay (per person):	$2 million on these plans

Short Term Medical Plans:		Value Select A	Plus Select A	Copay Select A	Plus Elite A
Length of Coverage		Choose length of coverage: from 30 days to less than 3 months.			
Deductible Type		Per Term (One deductible for selected length of coverage)			
Deductible Amount (per person)	You pay up to:	Choose $1,000[1], $2,500, $5,000, $10,000, or $12,500			
> Option: Add Supplemental Accident Benefit	We pay up to:	$1,000[1], $2,500, $5,000, $10,000, or $12,500 (Choose any amount to help cover your expenses in the case of an accident.)			
Coinsurance (% of covered expenses you pay after deductible)	You pay:	Choose 30% or 40%	Choose 20% or 40%	20%	0%
Coinsurance Out-of-pocket Maximum (after deductible, per person, copays not included)	You pay up to:	Choose $5,000 or $10,000	Choose $2,000, $5,000 or $10,000	$5,000	$0

Doctor Visits[2]

Doctor Office Visit, History, and Exam only	You pay:	Chosen coinsurance after deductible	Chosen coinsurance after deductible	$50 copay (first visit)[3]	Coinsurance after deductible
Urgent Care Center		$75 copay			

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Hospital Services	You pay:	Coinsurance after deductible

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Prescription (Rx) Drugs ($3,000 max benefit)	**Not covered.** Discount Card only[4]	**Preferred Price Card & coinsurance after deductible** You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us with the Preferred Price Card. Once your plan deductible is met, you then pay only your coinsurance.

[1] $1,000 option not available with the Plus Elite A plan.
[2] Expenses for injuries are eligible for coverage as of your plan's effective date; expenses for illnesses are eligible for coverage beginning on the 6th day following the effective date.
[3] Additional visits subject to deductible and coinsurance.
[4] Discount card can help you save an average of 20-25% on your Rx drugs. Discounts vary by pharmacy, geographic area, and drug.

Optional Benefit

Available for additional premium on all plans.

Supplemental Accident Optional Benefit Certificate Form 6-C-410

Reduce or eliminate your out-of-pocket exposure for accident-related injuries for additional premium. Supplemental Accident helps cover your deductible or other out-of-pocket medical expenses (before the health insurance starts paying covered expenses) for unexpected injuries. You select a maximum amount ($1,000,* $2,500, $5,000, $10,000 or $12,500) per accident, per covered person.

* **Note:** The $1,000 benefit amount is not an option with the Short Term Medical Plus Elite and Plus Elite A plans.

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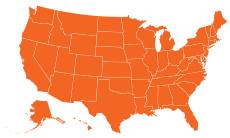
Short Term Medical
Choice Network States

All of our plans use a network of doctors, hospitals, and other providers that offer you quality health care.[1] **Visit UHOne.com and select Find A Doctor under Customer Center to search for UnitedHealthcare Choice network providers.**



Nationwide Network

Use any doctor in the Choice network across the nation. No Primary Care Physician (PCP) required. **Note: There are no non-network benefits.[1]**

Access to Quality Care from:

- Any network specialist without needing a referral.
- 1 million physicians and other health care professionals.[2]
- Approximately 6,000 hospitals and other facilities.[2]

No Balance Billing

Our network providers will not balance bill you for eligible expenses. Health care professionals in the network agree to provide you quality care at lower fees.

[1] These plans only pay benefits for eligible expenses from a network provider. No benefits are payable for non-emergency care from a non-network provider. Emergency treatment from a non-network provider will be treated as a network eligible service.

[2] UnitedHealth Group Annual Form 10-K for year ended 12/31/16.

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Medical Benefits (all plans)

The following medical benefits are provided using network providers and are subject to all policy provisions, the deductible, and any applicable copay or coinsurance (unless otherwise stated). You will find complete coverage details in the policy. See state variations on pages 9-12 for differences in the standard benefits below.

Ambulance Services

Ground ambulance service to a hospital for necessary emergency care.

Autism Spectrum Disorders

Outpatient applied behavior analysis limited to $50,000 per policy term, per covered person.

Dental Services

Dental expenses for an injury to natural teeth suffered after the coverage effective date. Expenses must be incurred within 6 months of the accident.

No benefits payable for injuries due to chewing as limited in the policy.

Diabetes

- Diabetes equipment, supplies, and services.
- Diabetes self-management training when medically necessary as determined by a physician, prescribed by a physician, and provided by an appropriately licensed health care professional limited to:
  - One diabetes self-management training program per covered person, per lifetime.
  - Additional diabetes self-management training prescribed by a physician as medically necessary due to a significant change in the covered person's symptoms or condition.

Diagnostic Testing

Durable Medical Equipment

Rental of wheelchair, hospital bed, and other durable medical equipment.

Home Health Care

Home health care prescribed and supervised by a doctor and provided by a licensed home health care agency. Covered expenses for home health aide services will be limited to 7 visits per week and a lifetime maximum of 365 visits. Benefits for home health care will not extend beyond the term of your plan. Each 8-hour period of home health aide services will be counted as one visit. Private duty registered nurse services will be limited to a lifetime maximum of 1,000 hours. Intermittent private duty registered nurse visits are not to exceed 4 hours each and are limited to $75 per visit (2 hours per visit are applied toward the lifetime maximum of registered nursing).

No benefits payable for respite care, custodial care, or educational care.

Hospital Services

Daily hospital room and board at most common semiprivate rate; eligible expenses for an intensive care unit; inpatient use of an operating, treatment, or recovery room; outpatient use of an operating, treatment, or recovery room for surgery; services and supplies, including drugs and medicines, which are routinely provided in the hospital to persons for use only while they are inpatients; emergency treatment of an injury or illness. Covered expenses for use of the emergency room are subject to a copayment of $250 for each emergency room visit.

Hospital does not include a nursing or convalescent home or an extended care facility.

Medical Supplies

- Dressings and other necessary medical supplies.
- Cost and administration of an anesthetic or oxygen.

Medical Benefits, continued (all plans)

Newborn Care

- Routine in-hospital care of a newborn for the first five days or until the mother is released which ever occurs first.
- Pregnancy not covered, except for complications.

Outpatient Surgery

Physician Fees

- Professional fees of doctors, medical practitioners, and surgeons.
- Assistant surgeon fee for a doctor, limited to 20% of eligible expenses of the procedure, and 14% of eligible expenses of the procedure for another medical professional acting as an assistant surgeon.

Preventive Care

- Children's preventive health services for covered children as defined in the certificate.
- Colorectal cancer examinations, prostate-specific antigen testing, and other preventive care as required by your state and specified in the certificate.

Rehabilitation and Extended Care Facility (ECF)

Must begin within 14 days of a 3-day or longer hospital stay for the same illness or injury. Limited to 60 days per policy term for both rehabilitation and ECF expenses.

Spine and Back Disorders

Benefits for treatment of spine and back disorders limited to $250 per person, per policy term.

Therapeutic Treatments

- Radiation therapy and chemotherapy.
- Hemodialysis, processing, and administration of blood or components (but not the cost of the actual blood or components).

Transplant Expense Benefit

The following transplants are covered the same as any other illness: cornea, artery or vein grafts, heart valve grafts, prosthetic tissue and joint replacement, and prosthetic lenses for cataracts.

For all other covered transplants, see your certificate for "Listed Transplants" under Transplant Expense Benefits. The covered person must be a good candidate, as determined by us. The transplant must not be experimental or investigational. Covered expenses for "Listed Transplants" are limited to 2 transplants per policy term, per covered person.

Golden Rule has arranged for certain hospitals around the country ("Centers of Excellence") to perform specified transplant services. If you use one of our "Centers of Excellence," the specified transplant will be considered the same as any other illness and will include transportation and lodging incentive (for a family member) of up to $5,000. If a "Center of Excellence" is not used, covered expenses for the "Listed Transplant" will be limited to one transplant in any 12-month period with a maximum benefit of $100,000 for all expenses associated with the transplant.

If a "Center of Excellence" is not used, the acquisition cost for the organ or bone marrow is not covered.

No benefits payable for:

- Search and testing in order to locate a suitable donor.
- A prophylactic bone harvest and peripheral blood stem cell collection when no "listed transplant" occurs.
- Animal-to-human transplants.
- Artificial or mechanical devices designed to replace a human organ temporarily or permanently.
- Procurement or transportation of the organ or tissue, unless expressly provided in this provision.
- Keeping a donor alive for the transplant operation.
- A live donor where the live donor is receiving a transplanted organ to replace the donated organ.
- A transplant under study in an ongoing Phase I or II clinical trial as set forth in the USFDA regulation.

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Short Term Medical State Variations

Please see below for state availability and applicable state-specific benefits, exclusions, and limitations.

Arizona

Certificate Form GRI-STAG16-C-EPO-02

There are no state variations.

Florida

Certificate Form C-016.1-09

- An unmarried, eligible child may remain covered through age 30.
- Routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care or treatment for purposes of determining preexisting conditions unless evidence of breast cancer is found during or as a result of the follow-up care.
- Transportation charges for a newborn to and from the nearest appropriate facility for medically necessary care limited to a maximum of $1,000.
- Covered expenses are expanded to include:
  - General anesthesia and services at a hospital or outpatient surgical facility for necessary dental care for an eligible child: less than 8 years old with a significantly complex dental condition or development disability for which treatment in a dental office would be ineffective; or who has one or more medical conditions that create a significant or undue risk if the necessary dental care was not performed in a hospital or outpatient surgical center.
  - Medically necessary services and treatment for cleft lip and palate for an eligible child under age 18.
  - Diagnostic or surgical procedures involving bones or joints of the jaw and facial region, if under accepted medical standards, the procedure or surgery is medically necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.

Illinois

Certificate Form C-016.1

- The definition of an eligible child is expanded to include an unmarried dependent under 30 years of age who: (a) Is an Illinois resident; (b) has served in the U.S. Armed Forces; (c) received a release or discharge other than dishonorable; and (d) has submitted a copy of a DD2-14 Certificate of Release or Discharge from active duty.
- The definition of “spouse” is expanded to include civil union partner.
- Covered expenses are expanded to include:
  - Inpatient treatment of alcoholism.
  - One pap smear each calendar year.
  - Surveillance test for ovarian cancer for covered females at risk.
  - One annual FDA-approved screening for human papillomavirus. The cost and administration of FDA-approved human papillomavirus vaccine.
  - Habilitative services for covered persons under age 19 diagnosed with a congenital, genetic, or early acquired syndrome. Treatment must be from licensed practitioners.
  - Medically necessary amino acid-based elemental formulas for the treatment of eosinophilic disorders or short bowel syndrome.
  - FDA-approved shingles vaccine, ordered by a doctor for persons age 60 and older.
  - Pain medication and therapy related to treatment of breast cancer to the same extent as any other illness.
  - Routine patient care incurred by a covered person in a qualified cancer trial to the same extent as coverage for routine patient care for a covered person not enrolled in a qualified clinical cancer trial. Specific details included in the certificate.
  - For a female covered person, one clinical breast exam per calendar year.
  - Breast cancer screening (exempt from deductible, copayments, coinsurance, when provided by a network provider) limited to: one routine mammography exam per calendar year for each female covered person; additional mammograms at medically necessary intervals; and a comprehensive ultrasound when a mammogram shows heterogeneous or dense breast tissue.
  - Contraceptive services including: drugs, devices and products approved by the FDA. (Exempt from deductible, copayments, coinsurance, when provided by a network provider).
- General exclusions and limitations are modified as follows: Covered expenses will not include, and no benefits will be paid for charges incurred for modification of the physical body in order to improve the psychological, mental, or emotional well-being of the covered person, except for charges for sex-change surgery or any other surgical or non-surgical treatment of gender dysphoria or gender identity disorder will be a covered expense, subject to all other limitations and exclusions of the certificate.

State Variations, continued

Please see below for state availability and applicable state-specific benefits, exclusions, and limitations.

Illinois, continued

Certificate Form C-016.1

- The definition of emergency is deleted and replaced with the following: "Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following: (a) Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) Serious impairment to bodily functions; or (c) Serious dysfunction of any bodily organ or part.

Iowa

Certificate Form GRI-STAG16-C-EPO-14

- The definition of "spouse" is expanded to include a partner in a civil union or same sex marriage.
- The $250 limit on the treatment of spine and back disorders does not apply.
- Covered expenses are expanded to include mammograms, vaccination for the human papilloma virus, and other preventive care as specified in the certificate.

Mississippi

Certificate Form C-016.1

- Covered expenses are expanded to include:
  - Charges for general anesthesia and associated facility fees incurred in conjunction with dental care (whether or not the dental care is covered) that is provided in a hospital or an outpatient surgical facility or dental office to a covered person as defined in the certificate.
  - Mammograms.
- Covered expenses do not include treatment of temporomandibular joint (TMJ) disorders.
- The definition of preexisting condition is replaced with: "Preexisting condition" means an injury or illness for which the covered person received medical advice, diagnosis, care or treatment was recommended to or received by a covered person within the 6 months immediately preceding the applicable effective date the covered person became insured under the certificate; or which, in the opinion of a qualified doctor: (1) probably began prior to the applicable effective date the covered person became insured under the certificate; and (2) manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within the 6 months immediately preceding the applicable effective date the covered person became insured under the certificate.

State Variations, continued

Please see below for state availability and applicable state-specific benefits, exclusions, and limitations.

Nebraska

Certificate Form C-016.1

- Mammography screenings are covered. Specific details in the certificate.
- The definition of emergency is deleted and replaced with the following: "Emergency" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

  A. Placing the health of the covered person afflicted in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy;

  B. Serious impairment to bodily functions; or

  C. Serious impairment of any bodily organ or part.

  D. Serious disfigurement of the covered person.

Texas

Certificate Form GRI-STAG16-C-EPO-42

- Covered expenses are expanded to include:
  - Additional diabetes services and equipment for covered persons with elevated glucose levels, as detailed in the certificate.
  - Emergency treatment that includes a hospital emergency room, freestanding emergency medical care facility, or comparable facility.
  - The most appropriate model of prosthetic device or orthotic device, as detailed in the certificate.
  - Diagnostic and surgical treatment of temporomandibular joint disorders and craniomandibular joint disorders.
  - Inpatient treatment of chemical dependency, in a hospital or chemical dependency treatment facility, is covered the same as any other illness. Treatment is limited to a lifetime maximum of 3 separate series for each covered person. No benefits for addiction to or dependency on tobacco products or foods, detoxification on an outpatient basis, or drug maintenance as opposed to rehabilitation.
  - Serious mental illness, covered the same as any other illness. Treatment limited to 45 days of inpatient treatment, and 60 days of outpatient visits per calendar year.
  - Screenings for autism spectrum disorder for an eligible child at 18 and 24 months of age.
  - Generally recognized services prescribed for the diagnosis and treatment of autism spectrum disorder for covered persons as detailed in the certificate.
  - Outpatient applied behavior analysis for the treatment of autism spectrum disorders, limited to a maximum of $50,000 per certificate term for covered persons 10 years of age or older.
  - Additional preventive health services, as detailed in the certificate.
- If a designated Center of Excellence is not used, covered expenses for a listed transplant will be reduced by 25% after application of any deductible amounts, coinsurance provisions, or copayment amounts.
- The definition of preexisting condition is replaced with: "Preexisting condition" means an injury or illness for which the covered person received medical advice or treatment within the 12 months immediately preceding the applicable effective date the covered person became insured under the certificate.

State Variations, continued

Please see below for state availability and applicable state-specific benefits, exclusions, and limitations.

West Virginia

Certificate Form C-016.1-47

- Covered expenses for diabetes self-management training services are deleted and replaced with the following: Covered expenses for diabetes self-management training services are limited to $100 per covered person, per calendar year.
- When determining covered expenses for dental expenses, injury will include damage to the natural teeth incurred as a result of chewing if the damage was caused by a non-edible foreign object found in food.
- Covered expenses are expanded to include:
  - An annual kidney disease screening using any combination of blood pressure testing, urine albumin or urine protein testing as recommended by the National Kidney Foundation.
  - Charges for general anesthesia, facility fees, and other related charges incurred in conjunction with dental care (but not the actual dental services) that are provided in a hospital or an outpatient surgical facility to a covered person as defined in the certificate.
- The following cancer screenings are covered: mammograms, pap smear, and HPV virus. Details are in the certificate.

Wisconsin

Certificate Form C-016.1

- A child called to active military duty prior to age 27 may be eligible after age 27 if a full-time student.
- Eligible children must be under 27 years of age at time of application. If age 26 at time of application, must also be unmarried.
- Home health aide services are limited to 40 home health care visits in a 12-month period. Specific details on Home Health Care Services are included in the certificate at issue.
- Kidney disease treatment is limited to dialysis, transplantation, and donor-related services. Maximum benefit is $30,000 per covered person annually.
- The $250 limit on the treatment of spine and back disorders does not apply.
- Treatment of temporomandibular joint (TMJ) is covered. Non-surgical treatment is limited to $1,250 per calendar year. Specific details included in certificate at issue.
- Treatment for mental or nervous disorders, including substance abuse, is covered the same as any other illness.
- Covered expenses are expanded to include:
  - Hospital or outpatient surgery center for general anesthesia and dental care to a covered person as defined in the certificate.
  - Mammography screenings as defined in the certificate.

What's not covered (all plans)

This is only a general outline of the coverage provisions and exclusions. It is not an insurance contract, nor part of the insurance policy/certificate. You will find complete coverage details in the policy/certificate Also see state variations on pages 9-12.

General Exclusions

Benefits will not be paid for services or supplies that are not administered or ordered by a doctor and medically necessary to the diagnosis or treatment of an illness or injury, as defined in the policy.

No benefits are payable for expenses:

- For non-emergency services or supplies received from a provider who is not a network provider, except as specifically provided for by the policy.
- For a preexisting condition — A condition: (1) for which medical advice, diagnosis, care, or treatment was recommended or received within the 24 months immediately preceding the date the covered person became insured under the policy/certificate; or (2) that had manifested itself in such a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 months immediately preceding the date the covered person became insured under the policy/certificate.
- A pregnancy existing on the effective date of coverage will also be considered a preexisting condition.
- **NOTE:** Even if you have had prior Golden Rule coverage and your preexisting conditions were covered under that plan, they will not be covered under this plan.
- That would not have been charged if you did not have insurance.
- Incurred while your coverage is not in force.
- Imposed on you by a provider (including a hospital) that are actually the responsibility of the provider to pay.
- For services performed by an immediate family member.
- That are not identified and included as covered expenses under the policy/certificate or are in excess of the eligible expenses.
- For services that are not covered expenses.
- For services or supplies that are provided prior to the effective date or after the termination date of the coverage.
- For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
- For breast reduction or augmentation.
- For drugs, treatment, or procedures that promote conception.
- For sterilization or reversals of sterilization.
- For fetal reduction surgery or abortion (unless life of mother would be endangered).
- For treatment of malocclusions, disorders of the temporomandibular joint (TMJ) or craniomandibular disorders.
- For modification of the physical body in order to improve psychological, mental, or emotional well-being, such as sex-change surgery.
- Not specifically provided for in the policy, including telephone consultations, failure to keep an appointment, television expenses, or telephone expenses.
- For marriage, family, or child counseling.
- For standby availability of a medical practitioner when no treatment is rendered.
- For hospital room and board and nursing services if admitted on a Friday or Saturday, unless for an emergency, or for medically necessary surgery that is scheduled for the next day.
- For dental expenses, including braces and oral surgery, except as provided for in the policy/certificate.
- For cosmetic treatment.
- For reconstructive surgery unless incidental to or following surgery or for a covered injury, or to correct a birth defect in a child who has been a covered person since childbirth until the surgery.
- For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
- For diagnosis or treatment of nicotine addiction.
- For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under Transplant Services.
- For high-dose chemotherapy prior to, in conjunction with, or supported by ABMT/BMT, except as specifically provided under the Transplant Expense Benefits provision.

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What's not covered, continued (all plans)

General Exclusions, continued

No benefits are payable for expenses:

- For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
- While confined for rehabilitation, custodial care, educational care, nursing services, or while at a residential treatment facility, except as provided for in the policy/certificate.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or any exam or fitting related to these devices, except as provided for in the policy/certificate.
- Due to pregnancy (except complications), except as provided in the policy/certificate.
- For diagnostic testing while confined primarily for well-baby care, except as provided in the policy/certificate.
- For treatment of mental disorders or substance abuse including court-ordered treatment for programs, except as provided in the policy/certificate.
- For preventive care or prophylactic care, including routine physical examinations, premarital examinations, and educational programs, except as provided in the policy/certificate.
- Incurred outside of the U.S., except for emergency treatment.
- Resulting from declared or undeclared war; intentionally self-inflicted bodily harm (whether sane or insane); or participation in a riot or felony (whether or not charged).
- For or related to durable medical equipment or for its fitting, implantation, adjustment or removal or for complications therefrom, except as provided for in the policy/certificate.
- For outpatient prescription drugs, except as provided for in the policy/certificate.
- For surrogate parenting
- For treatments of hyperhidrosis (excessive sweating).
- For alternative treatments, except as specifically covered by the policy/certificate, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.
- Resulting from or during employment for wage or profit, if covered or required to be covered by workers' compensation insurance under state or federal law. If you entered into a settlement that waives your right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply.
- Resulting from intoxication, as defined by state law where the illness or injury occurred, or while under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a doctor.
- For joint replacement, unless related to an injury covered by the policy/certificate.
- For non-emergency treatment of tonsils, adenoids, hemorrhoids or hernia.
- For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: sports (professional, or semi-professional, or intercollegiate except for intramural), parachute jumping, hang-gliding, racing or speed testing any motorized vehicle or conveyance, scuba/skin diving (when diving 60 or more feet in depth), skydiving, bungee jumping, or rodeo sports.
- For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following if the covered person is paid to participate or to instruct: operating or riding on a motorcycle, racing or speed testing any non-motorized vehicle or conveyance, horseback riding, rock or mountain climbing, or skiing.
- For injuries sustained while performing the duties of an aircraft crew member, including giving or receiving training on an aircraft.
- For vocational or recreational therapy, vocational rehabilitation, or occupational therapy, except as provided for in the policy/certificate.
- Resulting from experimental or investigational treatments, or unproven services.

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Other Details (all plans)

Coordination of Benefits (including Medicare)

If after coverage is issued, a covered person becomes insured under another health plan or Medicare, benefits will be determined under the Coordination of Benefits (COB) clause.

COB allows two or more plans to work together so the total amount of all benefits is never more than 100% of covered expenses. COB also takes into account medical coverage under auto insurance contracts. To determine which plan is primary, refer to "order of benefits" in the certificate.

Dependents

For purposes of this coverage, eligible dependents are your lawful spouse and eligible children. Eligible children must be under 26 years of age at time of application.

Effective Date

Expenses for injuries are eligible for coverage as of your plan's effective date; expenses for illnesses are eligible for coverage beginning on the 6th day following the effective date. Your certificate will take effect on the later of:

- The requested effective date on your application; or
- The day after the postmark date affixed by the U.S. Postal Service,* but only if the following conditions are satisfied:
  - A. Your application and the appropriate premium payment are actually received by us within 15 days of your signing;**
  - B. You are a member of the Federation of American Consumers and Travelers (FACT);
  - C. Your application is properly completed and unaltered;
  - D. You have answered "no" to question 2 (if other questions are answered "yes," we will exclude the person(s) listed);
  - E. You are a resident of a state in which the certificate form can be issued; and
  - F. If the application is submitted by an agent or broker, the agent or broker is properly licensed and appointed to submit applications to Golden Rule.

* If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of:
(1) the date you requested; or (2) the date received by Golden Rule. If the application is sent by any electronic means including fax, your coverage will take effect on the later of: (1) the requested effective date; or (2) the day after the date received by Golden Rule.

** Your account will be immediately charged.

Eligible Expense

An eligible expense means a covered expense as follows:

- **For Network Providers:** The contracted fee for the provider.
- **For Non-Network Providers:** As defined in the policy.

Emergency

"Emergency" means an unforeseen or sudden medical condition manifesting itself by acute signs or symptoms which could reasonably result in death or serious disability if medical attention is not provided within 24 hours.

No Non-Network Benefits

- **These plans only pay benefits for eligible expenses from a network provider.** Visit **UHOne.com** to search for providers.
- No benefits are payable for non-emergency care from a non-network provider.
- Emergency treatment from a non-network provider will be treated as a network eligible service. This means you will owe the difference between what the non-network provider bills and what we pay for a network eligible expense.

Non-Renewable

Your Short Term Medical certificate is not renewable.

We may cancel coverage if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim for benefits.

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HEALTH PLAN NOTICES OF PRIVACY PRACTICES
MEDICAL INFORMATION PRIVACY NOTICE

(Effective January 1, 2017)

We (including our affiliates listed at the end of this notice) are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you in our next annual distribution, either a revised notice or information about the material change or how to obtain a revised notice. We will provide this information either by direct mail or electronically in accordance with applicable law. In all cases, we will post the revised notice on our websites, such as *www.uhone.com, www.myuhone.com, www.myallsavers.com, or www.myallsaversmember.com.* We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our customers. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and Federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information. We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage and to process claims for health care services you receive including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection or compliance programs.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with Federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

- **For Workers' Compensation** including disclosures required by state workers' compensation laws that govern job-related injury or illness.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets Federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to Federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by Federal law.
- **Additional Restrictions on Use and Disclosure.** Certain Federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information: HIV/AIDS; mental health; genetic tests; alcohol and drug abuse; sexually transmitted diseases and reproductive health information; and child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by Federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under Federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights. The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a PO Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept verbal requests to receive confidential communications; however, we may also require you to confirm your request in writing. In addition, any request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of health information that we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have it sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend information** we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which Federal law does not require us to provide an accounting.

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. In addition, you may obtain a copy of this notice at our websites such as *www.uhone.com, www.myuhone.com, www.myallsavers.com, or www.myallsaversmember.com.*

  You have the right to be considered a protected person. (New Mexico only) A "protected person" is a victim of domestic abuse who also is either: (i) an applicant for insurance with us; (ii) a person who is or may be covered by our insurance; or (iii) someone who has a claim for benefits under our insurance.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the toll-free phone number on your health plan ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed below.
- **Submitting a Written Request.** Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record at the following address:
- Privacy Office, 7440 Woodland Drive, Indianapolis, IN 46278-1719
- **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

Fair Credit Reporting Act Notice. In some cases, we may ask a consumer-reporting agency to compile a consumer report, including potentially an investigative consumer report, about you. If we request an investigative consumer report, we will notify you promptly with the name and address of the agency that will furnish the report. You may request in writing to be interviewed as part of the investigation. The agency may retain a copy of the report. The agency may disclose it to other persons as allowed by the Federal Fair Credit Reporting Act.

We may disclose information solely about our transactions or experiences with you to our affiliates.

MIB. In conjunction with our membership in MIB, Inc., formerly known as Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a not-for-profit organization of life and health insurance companies that operates an information exchange on behalf of its members.

If you submit an application or claim for benefits to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply such company with information regarding you that it has in its file.

If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. Contact MIB at: MIB, Inc., 50 Braintree Hill Park Ste. 400, Braintree, MA 02184-8734, 1-866-692-6901, *www.mib.com*.

FINANCIAL INFORMATION PRIVACY NOTICE

(Effective January 1, 2017)

We (including our affiliates listed at the end of this notice) are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an insured or an applicant for coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing coverage to the individual.

Information We Collect. Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information. We do not disclose personal financial information about our insureds or former insureds to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

We restrict access to personal financial information about you to employees, affiliates and service providers who are involved in administering your health care coverage or providing services to you. We maintain physical, electronic and procedural safeguards that comply with Federal standards to guard your personal financial information.

Confidentiality and Security. We maintain physical, electronic and procedural safeguards, in accordance with applicable state and Federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice. If you have any questions about this notice, please **call the toll-free phone number on your health plan ID card.**

The Notice of Privacy Practices, effective January 1, 2017, is provided on behalf of All Savers Insurance Company; All Savers Life Insurance Company of California; Golden Rule Insurance Company; Oxford Health Insurance, Inc.; UnitedHealthcare Insurance Company; and UnitedHealthcare Life Insurance Company.

To obtain an authorization to release your personal information to another party, please go to the appropriate website listed in this Notice.

Who we are.

Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter of plans featured in this brochure. We have been serving the specific needs of individuals and families buying their own coverage for over 70 years. Plans are administered by United Healthcare Services, Inc.

Golden Rule Insurance Company is rated "A" (Excellent) by A.M. Best. This worldwide independent organization examines insurance companies and other businesses, and publishes its opinion about them. This rating is an indication of our financial strength and stability. (06/30/16)

Our plans offer easy-to-understand health insurance designed for individuals and families in times of transition and change. Plans only available to members of FACT, the Federation of American Consumers and Travelers (see below). If you're not already a member, you can enroll with your Short Term Medical application to be eligible to apply for these plans.

What is FACT?

FACT is an independent consumer association whose members benefit from the "pooling" of resources. Benefits range from medical savings to consumer service discounts. FACT's principal office is in Jonesboro, Arkansas. FACT and Golden Rule Insurance Company are separate organizations. Neither is responsible for the performance of the other. FACT has contracted with Golden Rule Insurance Company to provide its members with access to these health insurance plans. FACT does not receive any compensation from Golden Rule Insurance Company.

Is there a cost for joining FACT?

Yes, there are membership dues and they can be paid with your regular health insurance premium, as opposed to making a separate payment.

What are the basic FACT membership benefits?

FACT makes it easy for members to choose from a full menu of important benefits, including:

- Accidental Death Benefits
- Consumer Information & Hotline
- Retail & Service Discounts
- Travel Discounts
- Pet Coverage
- Scholarships

As a member of FACT, your information is kept private and is not shared with any third parties. Please visit the FACT website, usafact.org/privacy_policy.html, for a complete FACT Privacy Statement. FACT may change or discontinue any of its membership benefits at any time. For the most current information, including full detailed lists of member benefits, visit FACT's website at usafact.org or call toll-free at (800) USA-FACT.

Your Short Term Medical certificate is not renewable.
Short Term Medical is issued for a specific period of time. In most cases, coverage will be determined by the master policy issued in Arkansas and subject to Arkansas law. We will notify you in advance of any changes in coverage or benefits. Nonrefundable $20 application fee required.

UnitedHealthcare®
Golden Rule Insurance Company

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